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US Role [in Combatting Global AIDS Pandemic] Testimony, 7/22/99

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Testimony of

Timothy Dondero, M.D.

Chief

International Activities Branch

Division of HIV/AIDS Prevention

National Center for HIV, STD, and TB Prevention

Centers for Disease Control and Prevention

Before the

U.S. House of Representatives

Committee on Government Reform

Subcommittee on Criminal Justice,

Drug Policy, and Human Resources

JULY 22, 1999

I am Dr. Timothy Dondero, Chief of the International Activities Branch, Division of HIV/AIDS Prevention of the National Center for HIV, STD, and TB Prevention at the Centers for Disease Control and Prevention (CDC). Thank you for the opportunity to testify today about the magnitude of the global HIV/AIDS epidemic and CDC's international HIV/AIDS activities.

I will provide an overview summarizing the magnitude of HIV/AIDS epidemic and the closely intertwined tuberculosis (TB) and sexually transmitted diseases (STDs) epidemics worldwide. I will also highlight a few of CDC's international activities and discuss prevention approaches to reduce the impact of HIV/AIDS globally.

Background: Magnitude of Global HIV/AIDS, STDs and TB Epidemics

The HIV/AIDS epidemic continues to progress. More than 33.4 million people are estimated to be infected with HIV worldwide. Nearly 16,000 new infections occur each day, over 600 new infections every hour. Ninety-five percent of HIV-infected people live in the developing world -- and 95% of the deaths caused by HIV have occurred in developing countries. Unlike in the United States, most infections in the developing world are transmitted through heterosexual intercourse; the second most common route of transmission is from infected mothers to their children. In some areas, especially in Asia and here in the United States, HIV transmission through injection drug use is ~~locally~~ important; but for the world as a whole, drug-related HIV is responsible for only a modest part of the epidemic.

The most heavily impacted area of the world is sub-Saharan Africa, with over two-thirds of the world's infections and nearly 85% of the world's AIDS deaths. The next most affected region is south Asia and southeast Asia, with nearly 10% of the world's infections. These areas, and especially sub-Saharan Africa, are still experiencing explosive HIV epidemics that are taking an

enormous toll in human life and having a profound economic and social impact.

Currently it is estimated that there are 22 million adults and 1 million children living with HIV infection in sub-Saharan Africa and over six million infected persons in Asia. By comparison, the U.S. has an estimated ~~three-quarters~~three-quarters of a million persons living with HIV infection. An estimated four million new infections occur in sub-Saharan Africa each year, over six million throughout the world. The number of people losing their lives to AIDS ~~death toll~~ is rapidly rising with an estimated 5,500 deaths from the disease occurring each day in Africa. Without rapid implementation of large scale effective interventions most, if not all, of these national epidemics will continue to grow. Apart from the devastating human tragedy, t~~T~~here are many potential national and international consequences to this critical situation, including effects on political ~~and~~, economic, and military -stability ~~and other factors~~ that ~~could~~ will adversely affect U.S. national interests.

I would like to turn your attention to a figure that graphically illustrates the extremes to which the HIV epidemic has reached in the ~~populations of the~~ developing world. This figure shows the most recently available data (1996-98) for HIV infection in pregnant women from capital cities or major urban centers in Latin America, Asia, and Africa. HIV infection in pregnant women is a reasonable indicator of the levels in young adults in those countries generally and a direct indicator of the risk of mother to child infection.

COULD NOT SEE GRAPH

In the southern-most African countries, HIV has reached epidemic proportions only relatively recently. Botswana now has one of the highest documented rates of HIV infection in the world, with over 40% of ~~child~~ child-bearing women living in cities infected with HIV. Recent reports from four southern African countries, Botswana, Namibia, Swaziland, and Zimbabwe, indicate

that a fifth to a quarter of their entire adult populations aged 19-49 are now HIV-infected. The infection is wiping out recent gains in life expectancy. By the year 2010, for example, demographers project that life expectancy will have fallen from 66 to 33 years in Zambia and from 70 to 40 years in Zimbabwe.

While African countries have been severely affected by HIV disease, other countries including Thailand, Cambodia, and India, have also been impacted by the disease. India has perhaps the largest number of infections of any single country in the world, estimated between 3 and 5 million HIV infected individuals.

Global trends in HIV disease indicate that women are at greater risk than men from heterosexual transmission, and as the HIV epidemic matures in a region, individuals become infected at younger ages and the epidemic moves from high-risk groups to the general population. And infected women are the source of infection for their babies. Without interventions, roughly one quarter of the babies will become infected by the time of birth and an additional 5 to 15% will get infection through breast feeding.

When describing the global magnitude of HIV/AIDS, it is also important to note the interaction between HIV and other diseases, specifically tuberculosis (TB) and sexually transmitted diseases (STDs). The interactions are significant to the control of the HIV epidemic.

Worldwide, 8 million cases of tuberculosis and 3 million deaths occur annually, and 95% of these cases and 98% of the deaths occur in ~~low-income~~low-income countries. Tuberculosis kills more adolescents and adults than any other single infectious disease. The spread of the HIV epidemic has significantly increased the TB epidemic. While some increase in TB is due to demographic shifts in the population, much of the additional TB burden over the last 5 years, especially in Africa, can be attributed to the HIV epidemic. People who have latent, or inactive,

TB infection from exposure earlier in their lives run a high risk of developing active TB if they become infected with HIV, a risk 100 times greater than for someone without HIV infection. This enhancement in TB cases seriously increases the burden on the health care system and specifically on TB control services, already struggling to function in most developing countries, as well as increasing the reservoir of ~~tuberculous~~ tuberculosis infection to be spread to other people. More ominous still is that increased TB in AIDS patients enhances the potential for the spread of multi-drug resistant TB organisms, with negative consequences not only for the geographic areas heavily affected by HIV but for the U.S. and the world generally.

Evidence from epidemiologic studies on four continents has repeatedly linked the presence of sexually transmitted diseases with a two-to-five-fold increased risk for HIV transmission. In 1995, an estimated 333 million cases of four curable STDs (syphilis, gonorrhea, chlamydia, and trichomonas infection) were acquired worldwide, an increase from an estimated 298 million cases in 1990. STDs facilitate HIV transmission by increasing shedding of HIV and also enhance susceptibility to HIV through increasing the likelihood of HIV infection. HIV may also prolong the duration and infectiousness of some STDs, which increases the prevalence of these infections.

But as grim as this HIV, TB and STD situation is, there are ~~actually some glimmers~~ strong symbols of hope. One example is Uganda, where strong political leadership and a well-coordinated prevention campaign have resulted in significant reductions in the number of new HIV infections. ~~though there are some similar if less extensive signs of success in Tanzania, also in east Africa; and, in Cote d'Ivoire and Senegal, both in West Africa. Thailand has also seen improvements in some of it's hardest hit regions.~~

Over the past 4 to 5 years, Uganda, one of the sub-Saharan countries initially most heavily affected by the HIV/AIDS epidemic, has seen significant and encouraging reductions in the incidence and prevalence of HIV infection in its population. Young women attending antenatal

clinics have had a one-third reduction in HIV prevalence between the early 1990's and 1997 (from 32% infected in one area down to 22%), with continuing downward trends. Behavioral studies have shown a two or more year increase in age at first sexual intercourse in youths, a 9% reduction in casual sex, and a 30%-40% increase in condom use. These beneficial trends are attributed to a number of factors simultaneously occurring in Ugandan society.

There has been strong political leadership in efforts to increase AIDS awareness and prevention. The President and the First Lady themselves frequently address HIV-related issues, making them acceptable for public discussion. The Ugandan public is generally aware of HIV, including prevention needs and methods. In addition, Ugandan institutions, including religious groups, help provide a supportive and de-stigmatizing environment. Strong programs also exist for condom social marketing and for screening of transfused blood.

In addition, a very intensive HIV counseling and testing program, technically and fiscally supported by both CDC and USAID, has reached upwards of one-half million persons since 1990 through AIC (AIDS Information Center), a major non-government organization. This internationally acclaimed program, active in urban and rural areas, has functioned as an integral component of national programs for AIDS education and information and has contributed to AIDS surveillance.

There are similar signs of success in Tanzania, also in east Africa; and, in Cote d'Ivoire and Senegal, both in West Africa. Thailand has also seen improvements in some of its hardest hit regions.

Given the magnitude of the epidemic and the continuing explosive risk, and considering the economic and infrastructure realities of the regions of the world most affected, the most critical public health approach is prevention. Providing HIV treatment to the huge numbers of the world's HIV-infected poor people will be difficult in the near future for several reasons. Most

people with HIV infections are not aware that they are infected, and counseling and testing facilities are rare in the most affected developing countries. Most antiretroviral medications are very expensive, even with the reduced prices that UNAIDS has been able to negotiate with the drug manufacturers, and way beyond the $5 to $15 dollar per person annual expenditure on all of health services typical in these countries. Even if the drugs were available, the hospitals and clinical infrastructure are not currently equipped for the diagnostic work and laboratory monitoring most patients would need to really benefit from the treatment. TB screening of HIV-infected people and offering the low cost preventive medications for the other common opportunistic infections is more feasible than the expensive therapy aimed at the HIV virus itself.

CDC's Role in International HIV Activities

CDC focuses its international efforts by offering assistance to countries with the greatest public health need; conducting collaborative research and training on preventive interventions; serving as partners in global initiatives; and responding to national U.S. interests. We apply U.S. scientific advances in other countries, such as rapid HIV testing, prevention of mother-to-infant HIV transmission, refinement and installation of HIV diagnostic and research techniques, assisting in technical aspects of HIV surveillance, testing and counseling, applications of simple prevention of opportunistic infections, computerization of prevention and service providing groups, and studying the interactions of HIV and TB. ~~Some~~ Many of these activities involve a partnership with NIH, USAID, UNAIDS, and other international organizations. We also apply lessons learned in other countries to domestic disease control efforts.

CDC has a strong international field station structure in Cote d'Ivoire, Uganda, Kenya, and Botswana in Africa and Thailand in Asia, as well as a long history of providing technical assistance to these and many other countries. In addition to these sites, we have resident advisors relating to HIV and its associated diseases stationed in several places, including India, Bolivia, Indonesia, Vietnam, South Africa, and Mali (a number of these through USAID), and offer many short-term consultations on issues including surveillance, epidemiological assistance, training,

program management, blood supply protection, laboratory capacity building, and -prevention efforts.

At the global level, CDC assists by enhancing the capacity of the UN agencies committed to combating the epidemic through making technical experts available to UNAIDS, UNICEF, and WHO on both a long-term and a short basis. CDC also collaborates extensively with the US Agency for International Development (USAID), the World Health Organization (WHO), the Joint UN Programme on HIV/AIDS (UNAIDS), the United Nations Children's Fund (UNICEF) and the World Bank, as well as ministries of health around the world to provide both long and short term technical assistance and expertise.

Approach to the Epidemic: Prevention

One of the most critical needs in effective HIV/AIDS prevention is political will and political leadership within the country addressing, acknowledging, and focusing resources on HIV/AIDS prevention and control efforts. This key element of effective prevention can be provided only by the leadership in the country itself, though international partners and diplomatic missions can help to encourage and support this effort.

Critical to effective prevention is a well operating surveillance system. This is important so that the extent and trends of the epidemic can be monitored, prevention programs can be targeted and evaluated, priorities can be determined rationally, and the reality and extent of the epidemic can be acknowledged.

Sexual risk and transmission is addressed through behavior modification through the influence of culturally appropriate information and education, HIV counseling and testing, condom availability and social marketing, counseling and peer outreach to those at increased risk, and treatment of sexually transmitted infections. USAID and CDC, as well as other international agencies, provide technical assistance in these areas, but much more is needed. The cost of HIV

prevention is less expensive than treating the infection afterwards.

Prevention of mother-to-child transmission is now possible with the recent discoveries through the work of CDC and others that short-course administration of the antiretroviral drug AZT to pregnant women can provide a 50% reduction in transmission. Recent findings of an NIH-supported study of an even shorter and less expensive drug regimen -- one dose of the antiretroviral nevirapine to the mother in labor and one to the baby shortly thereafter -- offer even greater opportunities for reducing the likelihood of mother-~~infant~~-to-child transmission.~~prevention. Even with the cost of~~

HIV testing and counseling, -and ~~administration~~ the use of antiretroviral drugs for prevention, ~~such prevention is~~ are highly cost effective strategies. However, establishing prevention programs in settings where antenatal services may be weak is an operational challenge. In order to identify effective interventions, CDC is providing technical assistance to UNICEF pilot projects of mother-to-child HIV prevention in a number of sub-Saharan African countries.

Treating opportunistic infections of people living with AIDS~~patients~~, such as TB, is relatively inexpensive, dramatically lessens the impact of HIV and can improve quality of life. Approximately 2 billion people (one-third of the world's population) are infected with *Mycobacterium tuberculosis*, the cause of TB. TB is the cause of death for one out of every three people with AIDS worldwide. The high level of risk for dual HIV and TB infections underscores the critical need for targeted TB screening and preventive treatment programs for HIV-infected people and those at greatest risk for HIV infection. However, basic voluntary HIV counseling and testing services are generally not yet available for the tens of millions of persons living with HIV in Africa, who could benefit from these inexpensive and effective treatments.

Of course, o~~O~~ne of the most important prevention methods will be an effective vaccine. ~~Unfortunately, no vaccine is yet available.~~ A number of research groups are working on vaccine

development ~~including, prominently,~~ with the National Institutes of Health playing a leading role. Two field trials are currently underway, one of these in a developing country -- Thailand, and more are anticipated soon. Developing an effective and affordable vaccine is an extremely high priority for us and the entire Administration, but for the time being the other approaches to HIV prevention are all that we have. These approaches will remain essential even when a vaccine becomes available.

Antiretroviral therapies are a major piece of the prevention puzzle because they offer not only the possibility of prolonged life for ~~an~~ people living with HIV ~~infected~~ and AIDS ~~individual~~ but ~~because they~~ may also prevent mother-to-child HIV transmission and ~~may~~ reduce transmission of the virus from an infected person through sexual contact. However, as ~~I~~ previously mentioned, antiretoviral drugs are not widely available in developing countries, and their cost, unfortunately, competes for the limited resources available for other health services including HIV prevention.

[DO THE FOLLOWING CONCERNS RELATE TO PREVENTATIVE ANTIVIRAL THERAPIES (AZT AND NPV) OR TO HIGHLY-ACTIVE ANTIVIRAL COMBINATION THERAPY? SOME DISTINCTION SHOULD BE MADE.]

There are numerous current barriers to use of antiretroviral therapy of HIV/AIDS in developing countries, aside from the cost of the drugs themselves. These include lack of adequate health services and laboratory capability. Another serious consideration regarding extended therapy with antiretroviral drugs is that inappropriate treatment predisposes patients to development of drug resistant HIV. The appearance of drug resistance has already been found in Uganda after relatively few months of antiretroviral drug use. Since antiretroviral therapy is likely to be needed for a lifetime, the risk of developing of resistant HIV strains through inconsistent or partial treatment becomes a public health concern.

~~Antiretroviral therapy may become more affordable as partnerships are established among international agencies, governments and drug companies. Other cost reducing factors may include reduced drug dosages and reduction in drug prices.~~

In conclusion, ~~unless a consorted effort is undertaken to bring forth the political will, resources and expertise to implement effective prevention and treatment programs, the outlook for the global AIDS epidemic is bleak.~~ The situation is dire. AIDS is an epidemic of Biblical proportion, and has already caused untold pain and suffering. Yet there is hope. We can slow this epidemic as we work toward the development of a vaccine and a cure. That will require a response by the developing world that is of significantly higher magnitude than that currently underway. There will be no simple solutions. While drug therapies will be critical for both prevention and care, much more will have to be done to enhance prevention initiatives and to support the development of basic health infrastructures.

We look forward to a full partnership with Congress in our efforts to end this terrible epidemic. Thank you for allowing me the opportunity to appear before this Subcommittee.

ONE HUNDRED SIXTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON GOVERNMENT REFORM

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November 12, 1999

Ms. Sandra Thurman
Director, Office of National AIDS Policy
The White House
736 Jackson Place, NW
Washington, DC 20503

Dear Ms. Thurman:

On behalf of the members of the Subcommittee on Criminal Justice, Drug Policy and Human Resources, thank you for participating in the hearing entitled, "What is the United States' Role In Combating the Global AIDS Pandemic?" held on July 22, 1999. Your testimony was very informative.

Enclosed for your review is a copy of the testimony you provided at the hearing. Please review your statements for any errors that may have occurred during transcription. **Only grammatical and typographical errors may be corrected, no other changes will be permitted.** Please mark your corrections in red ink using standard editing symbols and initial each completed page.

If during your testimony documents were requested from you to be entered into the official record, please return those documents with your edits. If you do not respond within **fifteen days**, we will assume that there are no changes and will proceed with the printing of the publication.

Please note that stenographic minutes are unrevised and unedited and, therefore, are not for quotation or duplication. Copies of the transcript provided to you are to be used solely for the purpose of editing.

Please return your edits no later than **November 29, 1999** to Lisa Wandler, Subcommittee on Criminal Justice, Drug Policy and Human Resources, B-373 Rayburn House Office Building, Washington, D.C. 20515.

Once again, thank you for testifying at our hearing. Your participation is greatly appreciated.

Sincerely yours,

John Mica, Chairman
Subcommittee on Criminal Justice,
Drug Policy and Human Resources

are going to run the clock because we have another full panel after you. If you have lengthy statements, we will make them part of the record, or additional documentation, by unanimous consent.

First, I would like to recognize Ms. Sandra Thurman, the Director of the Office of National AIDS Policy for the White House. Welcome, and you are recognized.

TESTIMONY OF SANDRA THURMAN, DIRECTOR, OFFICE OF NATIONAL AIDS POLICY, THE WHITE HOUSE; JOSEPH PAPOVICH, ASSISTANT U.S. TRADE REPRESENTATIVE, SERVICES, INVESTMENT & INTELLECTUAL PROPERTY, UNITED STATES TRADE REPRESENTATIVE; JOHN KILLEN, DIRECTOR, DIVISION OF AIDS, NATIONAL INSTITUTE OF ALLERGY AND INFECTIOUS DISEASES, NATIONAL INSTITUTES OF HEALTH; AND TIMOTHY DONDERO, CHIEF OF THE INTERNATIONAL ACTIVITIES BRANCH, DIVISION OF HIV/AIDS PREVENTION, CENTER FOR DISEASE CONTROL AND PREVENTION

TESTIMONY OF SANDRA THURMAN

Ms. THURMAN. Thank you, Mr. Chairman. I knew I should not have released my report before I came to this committee, because most of you have already heard some of the statistics

out of it.

I just want to you to know how pleased I am to be with you here today. Your interest in addressing this crisis is very much appreciated, and your help is very much needed.

My colleagues from NIH and from CDC will again lay out for you a very vivid picture of the depth of this tragedy and describe for you some of the work that their agencies are doing to address the many challenges before us. You have heard the statistics, but you have also heard that these are not just numbers, but very real people and real lives.

I would like to take this time to talk with you a little bit about the human dimension of AIDS. AIDS truly is a plague of Biblical proportions. While many of us have witnessed firsthand the devastation, it is almost impossible to describe the grip that AIDS has on villages across Africa and on communities around the world. Twelve million men, women, and children in Africa have already died of AIDS, and yet the AIDS pandemic rages on.

In a host of different ways and from a variety of different vantage points, it is children who are caught in the cross-fire of this relentless epidemic. In Africa, an entire generation is in jeopardy.

In many sub-Saharan countries, between one-fifth and one-third of all children have already been orphaned by AIDS, and the worst is yet to come. Within the next decade, more

than 40 million children will have lost their parents to AIDS, 40 million. That is the equivalent of every child in the United States living east of the Mississippi.

AIDS is wiping out decades of hard work and steady progress in improving the lives and health of families throughout the developing world. For millions and millions of those families, and in some cases entire nations, AIDS is the engine of destruction that is pushing toward the brink of disaster. Not only do precious lives hang in the balance, but so, too, do the economic viability and the political stability of their homelands. As the Chairman has said, AIDS is a trade and investment issue, not just a health issue. Both in terms of exports and natural resources, Africa is a critical partner to the United States. A successful fight against AIDS is fundamentally important to our ability to sustain and improve our economic ties to Africa.

Skilled workers are taken in the prime of their lives, and in many instances companies are having to hire two people for every single skilled job they have, assuming one will die of AIDS.

AIDS is also a security and stability issue. The prevalence of HIV in the armed forces of many African countries is staggeringly high. The Economist has estimated that the HIV prevalence in the seven armies engaged in the Congo is somewhere between 50 and 80 percent of all military

personnel.

Other recent reports have projected that the South African military and police are also heavily impacted by HIV. Moreover, as these troops participate in an increasing number of regional interventions and peacekeeping operations, the epidemic is very likely to spread.

Yet my message here today to you is not one of hopelessness and desolation. On the contrary, I hope to share with you a sense of optimism. For amid all of this tragedy, there is great hope. Amid this terrible crisis, there is great opportunity. The opportunity is for us, working together, to empower women to protect children, and to support families and communities throughout Africa and throughout the world in ~~their~~ our shared struggle against AIDS.

The United States has been a leader in the struggle. The administration has taken an active role in sounding the alarm on the AIDS crisis in Africa, and in marshalling support for African efforts ~~to African efforts.~~ to combat this deadly disease. Since 1986, the U.S. Nation has contributed over $1 billion to the global fight against AIDS. More than 50 percent of those funds have been used to address the epidemic in sub-Saharan Africa. Overall, nearly half of all the development assistance devoted to HIV care and prevention in the developing world has come from the U.S.

The United States has also been the leading supporter of

the United Nations Joint Program on AIDS, or UNAIDS, contributing more than 25 percent of their budget. It is a strong record of engagement of which we can be proud, but unfortunately, it has not kept pace with this terrible epidemic. We have done much, but much more remains to be done by the United States and by the other developed nations.

In that spirit, on World AIDS Day in 1998, the President directed me to lead a fact-finding mission to sub-Saharan Africa and to make recommendations for an enhanced U.S. battle in our global fight against AIDS. I was pleased to lead that mission during the Easter recess, accompanied by Members and staff from both parties and both Chambers to witness firsthand the tragedies and triumphs of AIDS in Africa.

In response to that trip, as we all have heard, the President and the Vice President agreed we need to do more. This week the Administration announced a broad initiative to invest 100 million in the FY 2000 budget toward this effort. This initiative provides a series of steps to increase U.S. leadership through support for effective community-based solutions and technical assistance to developing nations.

This effort more than doubles our funding for programs of prevention and care in Africa, and challenges our G-8 partners and other partners to increase their efforts as well. This initiative is the largest increase in the U.S.

Government's investment in the global battle against AIDS, and it begins to reflect the magnitude of this rapidly escalating epidemic.

Our commitment to seek an additional $100 million in FY 2000 will help to support four key efforts: $48 million will be used for prevention, $23 million will be used to support community and home-based care, $10 million will go to take care of children who have been orphaned as a result of AIDS, and $19 million will be used to strengthen the infrastructure and to build capacity that we need to provide care to people who are infected throughout the African world.

We hope this initiative will receive the broad-based bipartisan support that it deserves. I greatly appreciate the favorable comments of the members of this committee about this initiative. AIDS is not a Democratic or Republican issue, it is a devastating human tragedy that cries out for all of us to help. I look forward to working with all of you.

On Monday, Bishop Tutu mentioned an African proverb which says: "When one steps on a thorn and it goes into the toe, the whole body bends down to pull it out." We ask for your help in doing that, in addressing this crisis of AIDS.

Thank you very much.

Mr. MICA. Thank you.

[The statement of Ms. Thurman follows:]

Mr. MICA. Unfortunately, we have a series of votes coming up. I am going to ask just a couple of quick questions.

I see the chart here, Ms. Thurman, about how the money is being expended. The bulk of it is for prevention, which is recommended by Congressman Berry and others, and we heard Ms. Nkhoma talk about people who are infected now. I do not see any money for treatment now. There is no money for treatment?

Ms. THURMAN. No, sir, there is money for treatment in the home-based and community care piece. There will be some money provided for medicines for opportunistic infections.

Mr. MICA. This says $23 million to deliver counseling, support, basic medical care.

Ms. THURMAN. Those medicines are included in the basic medical care.

Mr. MICA. That, again, is a concern.

Also my second part of this quick question to Mr. Papovich is that getting low-cost drugs available is a problem. It appears that it has not been our trade policy to encourage that actually. We have worked against that, as far as our policy in South Africa, which Mr. Jackson said should be the focus of our attention, because it sort of sets the pattern.

I will tell you what, I am not going to ask you to

Mr. MICA. I yield to the gentlewoman from Hawaii.

Mrs. MINK. Thank you. I have a whole host of questions, too.

While I appreciate the importance of prevention and education, I think the course of these hearings is really to investigate the issue of treatment and to what extent the U.S. Policies have related to this issue.

Ms. Thurman, could we have a 10-year listing of the efforts on treatment by the United States Government to African countries, and exactly, over the total budget, what percentage went to the treatment component?

Ms. THURMAN. Yes.

[The information follows:]

******** COMMITTEE INSERT ********

STATEMENT OF CONGRESSMAN HENRY A. WAXMAN
GOVERNMENT REFORM SUBCOMMITTEE ON CRIMINAL
JUSTICE, DRUG POLICY & HUMAN RESOURCES
HEARING ON THE U.S. ROLE IN COMBATTING THE GLOBAL HIV/AIDS EPIDEMIC

THURSDAY, JUNE 21, 1999
2154 RAYBURN HOB

Mr. Chairman, the topic of today's hearing is of tremendous importance to the health and security of all Americans. The HIV/AIDS epidemic knows no borders. Ending it requires us to sustain our global leadership in research and increase our ongoing support for the prevention, treatment and education efforts of other Nations and multilateral organizations, such as the World Health Organization.

I regret that this hearing only focuses on U.S. trade policies towards South Africa. It is an important, but limited topic. I hope that our inquiries in the future will extend to the adequacy of U.S. foreign assistance to combat HIV/AIDS and work of our Public Health Service in providing technical assistance to other countries. In that regard, I applaud this week's announcement by the Administration of an additional $100 million to combat HIV/AIDS in Africa and abroad.

But recent attention has focused instead on the actions taken by the U.S. Trade Representative regarding the South African Medicines Act of 1997. We should begin with a question — Why did South Africa adopt this law?

The South African law is meant to expand access to HIV/AIDS drugs. According to South African Health Minister Nkosazana Zuma, [HAW - pronounced "NOH-koh-sa-ZAN-na ZOO-ma"] one in eight South

African adults is HIV-positive. In the past year and a half alone, the prevalence of HIV has increased by a third to affect 3.4 million South Africans.

And if we look beyond South Africa's borders, 70 percent of all new HIV infections and 90 percent of all AIDS deaths occur in Subsaharan Africa. Yet only 1 percent of all HIV/AIDS drugs are sold in this region of the world.

No one questions the need to sustain a rigorous international regime of intellectual property protections. This is why the United States was signatory to the Uruguay Round Agreement. That is why we abide by TRIPS, the Agreement on Trade-Related Aspects of Intellectual Property Rights.

But I am concerned by the unusually aggressive and confrontational posture taken by our country towards the South African Medicines Act of 1997. According to the State Department's February 1999 report, U.S. opposition to the law began before its enactment, a position taken by "the State Department with the full support of USTR, Commerce/US Patent and Trademark Office and pharmaceutical industry representatives."

I find this statement notable for two reasons. First, the State Department invests the drug industry with the status of a sister agency of the United States Government. Second, the Department of Health and Human Services and the White House Office of National AIDS Policy are conspicuous in their absence from the statement.

In this same report, the State Department proudly asserts that, "The U.S. Government has made clear that it will defend the legitimate interests and rights of U.S. pharmaceutical firms."

I dearly hope that an impartial observer could also conclude that this Administration and this Congress dedicate the same vigor and energy to ending the HIV/AIDS epidemic as to defending the rights of the prescription drug industry. I hope the Administration's $100 million announcement signals a reconsideration of the apparent disregard for public health considerations in the State Department's February report.

In light of the palpable threat which South Africa faces from the HIV/AIDS epidemic, I believe we can do far more to help countries such as South Africa cope with the disastrous impact of AIDS by being less adversarial and confrontational. I would ask our foreign policy and trade agencies to consider the very real possibility that it is their position — and not the South African law — which will ultimately prove inconsistent with TRIPS.

Finally, I am concerned by the apparent failure of USTR and the State Department in their opposition to the South African law to consult with the agencies directly responsible for our public health response to the HIV/AIDS epidemic — the Department of Health and Human Services and the White House AIDS advisor, Sandy Thurman, who joins us today.

I thank the Chair for convening this hearing. I welcome our witnesses and look forward to their testimony on these issues.

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Testimony by

Sandra Thurman
Director, Office of National AIDS Policy

Before the

Committee on Government Reform
Subcommittee on Criminal Justice, Drug Policy and Human Resources

July 22, 1999

Mr. Chairman and other members of this Subcommittee, I am very pleased to be with you today to talk about the global AIDS pandemic. Your interest in addressing this crisis is very much appreciated.

My colleagues from the National Institutes of Health and the Centers for Disease Control and Prevention will lay out for you a vivid picture of the depth of this tragedy, and describe for you some of the work their agencies are supporting to address the many challenges before us. I would like to use this time with you to talk about the human dimension of the AIDS pandemic, and to share with you my experiences of the reality behind the many statistics you will hear today.

AIDS is a plague of Biblical proportion, and it is claiming more lives than all armed conflicts in this century combined. While many of us have witnessed its devastation firsthand, it is almost impossible to describe the grip that AIDS has on villages across Africa and on communities around the world. Twelve million men, women and children in Africa have already died of AIDS.

Today and everyday, AIDS in Africa buries more than 5,500 men, women and children – and that number will more than double in the next few years. AIDS is now the leading cause of death among all people of all ages in Africa – and among young adult African-American men in the United States.

And the epidemic rages on. Each day, 11,000 people in Africa become HIV infected – one every 8 seconds. Most of these new infections are among young people under the age of 25. And by 2005, more than 100 million people worldwide will have been infected with HIV. Without our help, without your help, the pace of these deaths will continue to accelerate.

And in a host of different ways and from a variety of different vantagepoints, it is children who are caught in the crossfire of this relentless epidemic. In Africa, an entire generation is in jeopardy. In many sub-Saharan Africa countries, between one-fifth and one-third of all children have already been orphaned by AIDS. And the worst is yet to come. Within the next decade, more than 40 million children will have lost one or both parents to AIDS. 40 million. That is about the same number as all children in public school in this country. Left unchecked, this tragedy will continue to escalate for at least another 30 years.

In just a few short years, AIDS will wipe out decades of hard work and steady progress in improving the lives and health of families throughout the developing world. In endemic regions, infant mortality will double, child mortality will triple, and life expectancy will be cut by 20 years or more.

For millions and millions of families, for large regions of the developing world, and in some cases for entire nations, AIDS is an engine of destruction that is pushing them to

the brink of disaster. Not only do millions of precious lives hang in the balance, but so too do the economic viability and political stability of their homelands.

AIDS is a trade and investment issue. Both in terms of exports and natural resources, Africa is a critical partner to the US economic engine. And a successful fight against AIDS is fundamentally important to our ability to sustain and improve our economic ties to Africa. Skilled workers are taken in the prime of their lives, forcing their companies to find and train new employees to take their place. As workers get sick, they can no longer afford to buy or produce products, so the economies of their countries suffer.

According to the *Economist* magazine, recent studies have found that AIDS is seriously eroding the economies of many of our partner nations. In Namibia, AIDS cost the country almost 8% of its GNP in 1996. By 2005, Kenya's GNP will be over 14% smaller than it would have been without AIDS.

Similarly, in Tanzania, The World Bank has predicted that its GNP will be 15 to 25% lower as a result of AIDS. The South African government has estimated that this epidemic costs the country 2% of its GNP each year, a situation that will only worsen without strong intervention.

AIDS is also a security and stability issue. The prevalence of HIV in the armed forces of many African countries is staggeringly high. The *Economist* has estimated the HIV prevalence in armed forces in the Congo range between 50 to 80%. Other recent

reports have projected that the South African military and police are also heavily impacted by HIV. Moreover, as these troops participate in an increasing number of regional interventions and peacekeeping operations, the epidemic is likely to spread.

Extremely high levels of HIV infection among senior officers could lead to rapid turnover in those positions. In countries where the military plays a central or strong role in government, such rapid turnover could weaken the central government's authority. For those countries in political transition, this kind of instability could slow or even reverse the transition process. This is a dynamic that deserves serious attention not only in Africa, but in the Newly Independent States of the Former Soviet Union, and in India where AIDS is intensifying its deadly grip.

The South African Institute for Security Studies has also linked the growing number of children orphaned by AIDS to future increases in crime and civil unrest. The assumption is that as the number of disaffected, troubled, and under-educated young people increases, many sub-Saharan African countries may face serious threats to their social stability. Without appropriate intervention, many of the 2 million children projected to be orphaned by AIDS in South Africa alone will raise themselves on the streets, often turning to crime, drugs, commercial sex, and gangs to survive. This seriously effects stability and promotes the spread of HIV among these highly vulnerable young people.

Yet my message to you today is not one of hopelessness and desolation. On the contrary, I hope to share with you a sense of optimism. For amidst all of this tragedy, there is hope. Amidst this terrible crisis, there is opportunity: the opportunity for us—working together—to empower women, to protect children, and to support families and communities throughout the world in our shared struggle against AIDS.

The United States has been active in the struggle. The Administration has taken an active role in sounding the alarm on the AIDS crisis in Africa, and in ensuring that the United States supports African efforts to combat this deadly disease.

Since 1986, this nation has contributed over $1 billion to the global fight against AIDS. More than 50% of those funds have been used to address the epidemic in sub-Saharan Africa. Overall, nearly half of all of the development assistance devoted to HIV care and prevention in the developing world has come from the US. The United States has also been the leading supporter of the United Nation's Joint Program on AIDS—UNAIDS—contributing more than 25% of its budget.

It is a strong record of engagement and one of which we can be proud, but unfortunately it has not kept pace with this terrible pandemic. We have done much, but there remains much more that we and the other developed nations can and must do.

In that spirit, on World AIDS Day 1998, the President directed me to lead a fact finding mission to sub-Saharan Africa and to report back with recommendations for an

enhanced US battle plan for our global fight against AIDS. I was pleased to lead that Presidential Mission during the Easter recess – accompanied by members and staff from both parties and chambers – to witness firsthand both the tragedies and triumphs of AIDS in Africa. In response to the findings of that trip, both the President and the Vice President agreed that we needed to respond to do more immediately and worked to develop an initiative to address this growing pandemic. This week, the Administration announced a broad new initiative to invest $100 million in the FY2000 budget for this effort.

This initiative provides for a series of steps to increase US leadership through support for effective community-based solutions and technical assistance to developing nations. This effort more than doubles our funding for programs of prevention and care in Africa, and challenges our G8 and other partners to similarly increase their efforts. This initiative is a significant increase in the US government's investment in the global battle against AIDS and it begins to reflect the magnitude of this rapidly escalating pandemic.

A critical component of this initiative is a commitment to seek an additional $100 million in Fiscal Year 2000 funds to help support this battle. Four key investments have been identified:

- $48 million will be used for prevention. Specifically, we hope to implement a variety of prevention and stigma reduction strategies, especially for women and youth, including: HIV education, engagement of political, religious, and civic

leaders, voluntary counseling and testing, interventions to reduce mother-to-child transmission, and enhanced training and technical assistance programs.

- $23 million will support home and community-based care. This will help create and enhance counseling and support systems, and help clinics and home health workers provide basic medical care (including treatment for related illnesses like STDs and TB)
- $10 million will go for the care of children orphaned by AIDS. This will allow us to continue efforts that are being started this fiscal year through funds supported by Representatives Callahan and Pelosi and their colleagues. We hope to improve our ability to assist families and communities in caring for their orphaned children through nutritional assistance, education, training, health, and counseling support, in coordination with micro-enterprise programs.
- And $19 million will be used to strengthen prevention and treatment infrastructure. These funds will help to increase the capacity for the effective delivery of essential services through governments, NGOs, and the private sector. We also need to enhance surveillance systems so that we can better track the epidemic and target HIV prevention efforts.

This assistance will come through the combined work of three Federal agencies: the US Agency for International Development would utilize $55 million, HHS would invest $35 million, and the Department of Defense the remaining $10 million.

Some of the other key components of this initiative include an increase in our efforts to include the AIDS epidemic in our foreign policy dialogue, both to support political leadership in countries hardest hit and to promote an increased response by our developed nation partners. We are also taking steps to increase our coordination with the private sector and the many non-governmental organizations working in endemic regions, including religious organizations.

We hope that this initiative will receive the broad-based bipartisan support it deserves. AIDS is not a democratic or republican issue – it is a devastating human tragedy that cries out to all of us for help.

You will find a more complete description of this initiative and the problems it seeks to address in the report released by the Administration earlier this week. I have submitted a copy to this Subcommittee and would like to request that it be included in the record as part of my remarks.

Let me conclude by thanking this Subcommittee for its interest in this issue, and offer my continued assistance as you seek ways to respond to this terrible tragedy. Not too many years ago, the Reverend Martin Luther King, Jr. said:

> We are caught in an inescapable network of mutuality, tied in a single garment of destiny. Whatever affects one directly affects all indirectly.

Last week, Archbishop Tutu expressed the same sentiment through an African proverb:

When one steps on a thorn and it goes into the toe, the whole body bends to pull it out.

We are one world – and in many ways – Africa's destiny is our destiny. Every day, another 16,000 people around the world are infected with HIV, and 90% of those live in our poorest nations. There is hope, but that hope will only be realized if we act. We are not at the beginning of the end of AIDS, but rather at the end of the beginning. Our resolve to stop this epidemic must be strengthened, our resources significantly increased, our determination made clear. Let us hope and pray that we have the foresight and the fortitude to seize this opportunity.

I thank the Chairman and this Committee for allowing me to be with you here today.

From OMB

AIDS Initiative: Qs & As

For Internal Use Only

VP and South Africa

Q: Is this initiative a response to the recent problems facing the Vice President on international patents in South Africa?

A: No. The President, the Vice President and others throughout this Administration recognize the critical nature of this pandemic and is committed to helping the African people combat AIDS. This effort began on December 1, 1998 (World AIDS Day) when the President and Vice President focused attention on this issue and directed AIDS czar Sandy Thurman to lead a fact finding mission to sub-Saharan Africa and report back with recommendations. Today we are releasing a report from Director Thurman and moving forward on the Plan of Action.

The Vice President has worked with President Mbeki and other African leaders to address the crisis of AIDS and worked with Director Thurman and others to assure that the Administration responded to the recommendations of Director Thurman's report. The Vice President looks forward to continuing to work to find ways to address this problem.

Q: How is the budget amendment being paid for?

A: This new proposed investment of $100 million is fully paid for. The Office of Management and Budget worked with many agencies to come up with a series of reasonable offsets, such as areas where appropriated funds are in excess of what is needed. These include:

Sources of funds for initiative

$40 million comes from unspent activities at the Department of Justice for enforcement activities against unlawful diversion of prescription drug medications.

$30 million in unobligated balances from the National Institutes of Health Buildings and Facilities still available because they were not spent last year.

$10 million in balances from the Agency for International Development Sustainable Development Assistance Account in appropriate funds that exceeds projected expenditures for development accounts.

$10 million comes from a small percentage of unobligated commodity funding in the International Assistance Programs and prioritized for AIDS orphans.

$10 million from the Department of Defense from sales of excess raw minerals no longer needed.

Q: Are any of these funds being taken from existing AIDS programs, Africa programs, or programs to support orphans?

A: None of the funds are being shifted away from AIDS, Africa or programs which provide support to orphans. These funds are additional to what is currently being spent on both AIDS and Africa.

Q: Does this initiative really double funding for prevention and treatment in Africa?

A. The United States Government currently spends $81 million in prevention and treatment. This new $100 million proposed for FY2000 represents a more than doubling of our investments in this area. We also are hopeful that this level of commitment will encourage other nations to step up their efforts. We need many nations and private sector commitments to address a problem of this magnitude.

Q: Has funding been allocated for FY2001?

A: The difficult battle against AIDS will require sustained attention from the US government, other bilateral and multilateral donors and especially from the African nations themselves for many years. Our goals, which are coordinated with the UNAIDS program goals, are five year goals. We are committed to working towards reaching these important goals.

(IF PRESSED:) We have not made any funding commitments beyond the year 2000. However, recognizing the extreme need, we anticipate future funding commitments will be part of our sustained effort.

Q: How will the US Government accomplish the goals described with only $100 million in FY2000?

A: The goals are part of a larger strategy to battle AIDS outside the U.S., primarily in Sub-Saharan Africa. Our initiative seeks to link the US comparative advantage in assisting developing countries battle AIDS with that of other bilateral and multilateral donors, as well as on the host countries themselves. The battle against AIDS can not be won by the US alone or in one year. Although US leadership is a critical component of the effort, there must be a substantial effort on the part of other donors and the African nations themselves. The goals of the initiative, developed in coordination with UNAIDS, are part of a five year strategy. The global effort of all parties must be sustained over time to address this urgent problem. In addition, the US is contributing in ways beyond the $100 million. On September 7, 1999, First Lady Hillary Rodham Clinton will convene a meeting of donors, the World Bank, UNAIDS, international foundations, CEOs and others to discuss how we can best enhance and coordinate our efforts in Africa and around the world.

Q: How will you ensure that other countries donate and how much funding do you expect in total?

A: This new USG initiative demonstrates the US commitment to and leadership in fighting the AIDS pandemic. The US contribution will seek to leverage the commitment and resources necessary from other bilateral and multilateral donors, and host nations themselves to address this challenge. The US will challenge other developed countries to participate in the global effort to achieve the goals laid out through our initiative and the UNAIDS program.

Q: How did you choose the countries in which to focus your efforts?

A: Countries will be chosen based on a combination of factors. The most important factor is the receptivity of host countries to partnering. Other factors to be considered include the adult HIV prevalence rates, the potential for impact, the rate of increase in HIV, the status of ongoing programs, the political commitment of governments and the opportunity for innovation.

Q: Will the new treatment for reducing mother to child HIV transmission (nevirapine/Viramune) reduce the cost of this initiative?

A: We are excited about the potential of this new drug and will be evaluating how it fits into our treatment plans.

Q. What sorts of activities will the Department of Defense conduct associated with this initiative?

A. The Department of Defense already conducts a wide variety of activities aimed at educating its own service members to prevent HIV infection. Upon entry, every service member undergoes training to promote responsible behavior. This training includes in-depth explanation of how an individual does or does not contract HIV. Through questionnaires or examinations, at risk persons are identified and further counseled on an individual basis. Following their initial training, service members receive periodic counseling on an as-needed basis.

The Department of Defense will use this practical experience to help prevent the spread of HIV in Africa. As part of on-going medical exercises and organizational exchanges, DoD will engage with African countries to educate and provide prevention activities to African military personnel.

Q: How much of the $100 million goes towards prevention? towards treatment?

A: $48 million will primarily go towards prevention and $23 million for treatment of sexually transmitted diseases and opportunistic infections. Of the remaining dollars, $10 million will provide care for children orphaned by AIDS and $19 million will strengthen prevention and treatment by augmenting planning, infrastructure, disease surveillance and capacity development.